College Hospitals
Costa Mesa

Benefit Guide for Employees

2024 – 2025 Plan Year

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WELCOME TO YOUR BENEFITS GUIDE

SCAN ME

At College Hospital Costa Mesa, we believe that you, our employees, are our most important asset. Helping you and your families achieve and maintain good health—physical, emotional, and financial—is the reason College Health Enterprises offers you this benefits program. We are providing you with this overview to help you understand the benefits that are available to you and how to best use them.

It's important to learn about the coverage options available to you, compare the features and costs, and decide which options are best for your individual situation and budget. Be sure to consider not only the premiums for each plan, but also the out-of-pocket cost; deductibles, copays, and coinsurance. If you have any questions about your benefits, eligibility or how to enroll, please contact Human Resources. A list of plan contacts is provided at the back of this summary.

While we've made every effort to make sure that this guide is comprehensive, it cannot provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid. A list of plan contacts is included at the back of this guide.

This Guide Is An Overview

The benefits in this summary are effective

March 1, 2024 through February 28, 2025

Medicare Part D Notice: *If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Annual Notices in the accompanying Annual Notices document for more details.*

ELIGIBILITY & ENROLLMENT

WHO IS ELIGIBLE?

If you are hired as a full-time employee working an average of at least 30 or more hours per week, then you are eligible for benefits the first day of the month following 30 days from the date of hire or transfer from part-time to full-time status.

You may enroll your eligible dependents for coverage once you are eligible. Your eligible dependents include the following:

- Your **legal spouse**
- Your registered domestic partner
- Your child(ren) of any age who are incapable of self-sustaining employment by reason of mental or physical disability and supported primarily by you
- Your **children up to age 26**, including natural and adopted children, stepchildren and any other children you support for whom you are the legal guardian or for whom you are required to provide coverage as the result of a qualified medical child support order

If you do not enroll for insurance within your first 31 days of becoming eligible for benefits with College Health Enterprises, you will need to wait for the next open enrollment. Once your benefit elections become effective, they remain in effect until the end of the plan year. You may only change coverage within 31 days of a qualified life event.

QUALIFIED LIFE EVENTS

The benefits you elect are binding for the entire plan year, unless you experience a qualified life event, such as:

- Marriage
- Divorce or legal separation
- Birth of your child
- Death of your spouse or dependent child
- Adoption of or placement for adoption of your child
- Dependent's loss of eligibility due to age or student status change
- Gain/loss of group insurance coverage
- Medicare or State Assistance
- Family Medical Leave

You must notify Human Resources within 31 days of the qualified life event. Depending on the type of event, you may be asked to provide proof of the event. If you do not contact Human Resources within 31 days of the qualified event, you will have to wait until the next annual enrollment period to make changes (unless you experience another qualified life event).

HOW TO ENROLL

IF YOU NEED HELP

Contact Human Resources at

949-574-3385

College Hospital Costa Mesa uses paycom for online benefit enrollment. Here are some tips to help you get started.

BEFORE YOU ENROLL

- Collect the date of birth, Social Security Number (SSN), and address for each dependent and/or beneficiary you wish to include.
- Consider your needs and the needs of your eligible dependents.
- Review any benefits offered through your spouse's employer to avoid costly duplicate coverage.
- Carefully review the information in this benefits summary and other enrollment materials.

ENROLL ONLINE

If you have not already created your paycom log-in, please do so by the following the steps below:

1. Go to www.paycomeonline.net
2. Click on the Login button
3. Click Employee
4. Type in your assigned username, password and last four digits of your SSN. (If you don't have an assigned username please reach out to Human Resources)
5. Once logged in you will be prompted to 5 security questions and prompted to change your password.

Please take some time to click on the tabs once you are logged in to become familiar with the UKG system. You can edit personal information such as address, phone number, W4 information. You can also view your benefits and accruals, request time off, and prove your time.

HEALTHCARE

MAKE TIME FOR HEALTH

OUR COMMITMENT

We believe that our employees should have access to healthcare coverage that promotes preventive care and helps cover the cost of illness.

Eligible employees and their eligible dependents can enroll in medical, dental, and vision coverage through the College Health Enterprises benefits program.

Medical

We offer **four** end-user comprehensive medical plans options including The Difference Card benefit. Preventive care is fully covered under all plans if obtained in-network. Your costs for other services will depend on which plan you choose. Review the network provider information and out-of-pocket costs such as deductible, co-insurance and prescription drugs so you can choose the best fit for your health concerns and budget/understand how the plan works.

Dental

Some people don't like going to the dentist, but no one likes big dental bills. Regular checkups and cleanings are fully covered and can identify issues before they become serious. And if you do need dental services, insurance helps cover the cost for fillings, gum disease, orthodontia, and more.

Vision

An eye exam can uncover health conditions you may not know you have, such as glaucoma, or even high blood pressure. Our vision plan helps cover the cost of eye exams, eyeglasses, and contact lenses to ensure you're seeing and feeling your best.

MEDICAL

OUR PLANS

- Aetna **HMO AVN** Plan
- Aetna **HMO FULL** Plan
- Aetna **MC POS (PPO)** Plan
- Kaiser **HMO** *with The Difference Card* Plan

WHICH PLAN IS RIGHT FOR YOU?

That depends on your healthcare needs, favorite doctors, and budget. Here are some considerations.

DO YOU PREFER SPECIFIC DOCTORS OR HOSPITALS?

If you want to stay with your favorite doctors and facilities, check whether they are in the plan's network. If they are not, but you are comfortable paying a bit more to see them, consider a plan with both in-network and out-of-network benefits.

WHAT ARE YOUR USUAL HEALTHCARE NEEDS?

Do you have frequent doctor or urgent care visits? Do you have a condition that requires a specialist? Do you take prescription medications? Compare how each plan covers the services you need most often.

CONSIDER THE BOTTOM LINE

How much is the monthly payroll deduction? Do you have to meet a deductible? What is the out-of-pocket maximum? How much of the cost is covered by the plan? How much are any co-payments for office visits, prescriptions, etc. All of these factors together affect your total cost for healthcare.

WHICH PLAN IS RIGHT FOR YOU?

Consider an HMO (health maintenance organization) if:

- You want lower, predictable out-of-pocket costs.
- You like having one doctor to manage your care.
- You are happy with the selection of network providers.
- You don't see any doctors that are out-of-network.

Plans To Consider

- Aetna **HMO AVN** Plan
- Aetna **HMO FULL** Plan
- Kaiser **HMO** *with The Difference Card* Plan

Consider a POS (point of service) if:

- You want access to both in- and out-of-network providers.
- You like having one doctor to manage your in-network care.
- You are willing to pay more to see out-of-network providers

Plans To Consider

- Aetna **MC POS (PPO)** Plan

FIND OUT IF YOUR DOCTOR IS IN-NETWORK:

Click Here for **Aetna HMO AVN** Network

Click Here for **Aetna HMO Full** Network

Click Here for **Kaiser HMO** Network

Click Here for **Aetna MC POS (PPO)** Network

KAISER HMO WITH DIFFERENCE CARD

College Health Enterprises has partnered with the Difference Card in conjunction with Kaiser. Kaiser is your insurance carrier and processes your claims submitted by your doctors. The Difference Card helps you pay for, or obtain reimbursement for, out-of-pocket expenses you may incur under your Kaiser plan, including inpatient stays, emergency room co-pays, deductibles and co-insurance expenses. These expenses are paid from funds set aside by College Health Enterprises.

1. Please remember that with the new Kaiser plan, you will be charged for the entire cost of the visit until you have reached your out of pocket maximum.

2. When visiting your Kaiser facility, simply swipe the Difference Card Mastercard to pay your bill. This includes office visits, procedures, tests, prescriptions etc.

3. If you forget to use your Difference Card, you will need to submit the Kaiser statement to The Difference Card so you can be reimbursed.

4. The Difference Card will require post transaction substantiation for any swipe that exceeds $1,000. When that occurs, submit the Kaiser statement that corresponds to the transaction. If you don't provide the necessary substantiation when prompted, your Difference Card Mastercard will be deactivated. It will be reactivated as soon as the Kaiser statement is received by The Difference Card.

5. Manual reimbursements and claim substantiation can be submitted via DifferenceCard.com or through the Difference Card mobile app. Details below.

Kaiser EOBs will be available online at https://healthy.kaiserpermanente.org for your reference. Be sure to create an account and become a registered user.

Access your Difference Card account online

- Log on to www.differencecard.com
- For first-time users, your username is your full SSN

Difference Card Customer Care can answer any questions you may have. Their hours are:

- Monday-Friday 9:00 am – 8:00 pm EST
- Phone: 888-343-2110

The only way to be reimbursed is to link your bank account for direct deposit. Visit **www.differencard.com** to sign up.

KAISER HMO WITH DIFFERENCE CARD

KAISER HMO WITH THE DIFFERENCE CARD PLAN

College Health Enterprises has partnered with The Difference Card in conjunction with your Kaiser plan. Kaiser is your insurance carrier. The Difference Card is what you will use to pay for all services approved by Kaiser. These expenses are paid from funds set aside by College Health Enterprises.

	Kaiser Benefit	College Hospital (Cerritos) Pays Through Difference Card*	You Pay
In-Network			
Primary Care Copay	Deductible then $50	Deductible then $50	$0
Specialist Copay	Deductible then $50	Deductible then $50	$0
Preventative Care	No Charge		
Urgent Care Copay	Deductible then $50	Deductible then $50	$0
In-Network Deductible (Individual / Family)	$5,500 / $11,000	$5,500 / $11,000	$0
In-Network Coinsurance Limit (Individual / Family)	$2,000 / $4,000	$2,000 / $4,000	$0
Hospital Services			
Emergency Room Copay	40% after deductible	40% after deductible	$0
Outpatient Surgery	40% after deductible	40% after deductible	$0
Inpatient Hospital	40% after deductible	40% after deductible	$0
Diagnostic Procedures			
Diagnostic Test - Lab Work	40% after deductible	40% after deductible	$0
Diagnostic Test - X-Ray	40% after deductible	40% after deductible	$0
Complex Imaging (CT/Pet Scans, MRIs)	40% after deductible	40% after deductible	$0
Out-of-Network			
Out-of-Network Deductible	Not Covered		
Out-of-Network Coinsurance Limit	Not Covered		
Pharmacy			
Prescription Deductible	Integrated with Medical Deductible		
Retail Prescriptions	$15/40% to $100/40% to $250	100%	$0
Mail Order Prescriptions (*90 Day Supply)*	$30/40% to $200/40% to $500	100%	$0
Cost Per Pay Period (Bi-Weekly)	**Kaiser Benefit with The Difference Card**		
Employee Only	$70.52		
Employee + 1	$205.16		
Employee + 2 or more	$344.74		

CLICK HERE for more detailed information on The Difference Card and Kaiser Medical Plan
PASSCODE: #CHE2024

ACCESS YOUR DIFFERENCE CARD ACCOUNT ONLINE

The Difference Card Participant Portal can be easily accessed at www.differencecard.com

- Log on to www.differencecard.com
- Your username is your Social Security Number
- Your password is your birthdate (MMDDYYYY)
- Enter the "scrambled" code and then click on the purple "Enter" button
- You'll know you've logged on properly when you see the "Welcome" prompt at the top right of your screen
- One you're logged on, click on the "Participant Portal" tab on the top of the screen. If a provider requires you to pay out-of-pocket in full, claims may be submitted online, faxed, or mailed to:

Mail	The Difference Card PO Box 322 Mount Kisco, NY 10549
Fax	(914) 220-0901
Email	customercare@differencecard.com
Call	(888) 343-2110

IMPORTANT: Keep all your receipts and EOBs related to your Difference Card reimbursement. You will need to provide backup documents to the Difference Card to submit a claim for reimbursement. All claims must be submitted within 3 months of the end of the plan year.

Difference Card (DC) Mobile App – Manage your account on the go!

- The DC Mobile App provides an easy way to view your account balance, see transaction details, submit a claim, view pending claims, and access important messages from The Difference Card.
- To download the app, search for "Difference Card Mobile" in the app store of your device.
- You must register with the app, even if you have already registered on the Difference Card website.
- For step-by-step instructions on how to register with the app and other helpful information, visit www.differencecard.com/members/mobileapp.

SCAN ME

MEDICAL BENEFITS – AETNA HMO

	Aetna HMO AVN	Aetna HMO Full
In-Network		
Primary Care Copay	$30 Copay	$20 Copay
Primary Care Physician Section	Required	Required
Referral Requirement	Required	Required
Specialist Copay	$30 Copay	$20 Copay
In-Network Deductible		
Individual	$0	$0
Family	$0	$0
Preventative Care	Covered at 100%	Covered at 100%
Inpatient Hospitalization	You pay 20%	$250 Copay
Outpatient Surgery	You pay 20%	$250 Copay
Emergency Room	$50 Copay	$100 Copay
Urgent Care	$30 Copay	$20 Copay
Chiropractic	$15 Copay	$15 Copay
Annual Visit Limits	30 Visit	30 Visit
Acupuncture	$15 Copay	$15 Copay
Annual Visit Limits	20 Visits	20 Visits
Out-of-Pocket Maximum		
Individual	$1,500	$1,500
Family	$4,500	$4,500
Pharmacy		
Prescription Deductible	$0	$0
Retail Prescriptions		
Generic	$10 Copay	$10 Copay
Preferred	$30 Copay	$25 Copay
Non-Preferred	$50 Copay	$40 Copay
Specialty	30% up to a maximum of $250	20% up to a maximum of $100
Mail Order Prescriptions		
Generic	$20 Copay	$20 Copay
Preferred	$75 Copay	$50 Copay
Non-Preferred	$125 Copay	$80 Copay
Specialty	30% up to a maximum of $250	20% up to a maximum of $100
Cost Per Pay Period (Bi-Weekly)	**Aetna HMO AVN**	**Aetna HMO Full**
Employee Only	$0.00	$85.98
Employee + 1	$73.52	$265.20
Employee + 2 or more	$140.12	$441.08

MEDICAL BENEFITS – AETNA PPO

Aetna MC POS (PPO) Plan		
	In-Network	**Out-of-Network**
Primary Care Copay	$30 Copay	40% after deductible
Specialist Copay	$50 Copay	40% after deductible
Deductible		
Individual	$500	$2,000
Family	$1,500	$6,000
Preventative Care	Covered at 100%	Covered at 100%
Inpatient Hospitalization	20% after deductible	40% after deductible
Outpatient Surgery	20% after deductible	40% after deductible
Emergency Room	$100 Copay then 20% coinsurance	
Urgent Care	$50 Copay	40% after deductible
Chiropractic *Annual Visit Limits*	$20 Copay 12 Visit	40% after deductible 12 Visits
Acupuncture *Annual Visit Limits*	$20 Copay 12 Visit	40% after deductible 12 Visits
Out-of-Pocket Maximum		
Individual	$4,000	$8,000
Family	$12,000	$24,000
Pharmacy		
Prescription Deductible Individual / Family	$100 / $200	$100 / $200
Retail Prescriptions		
Generic	$15 Copay (30 Day Supply) $30 Copay (60 Day Supply) $45 Copay (90 Day Supply)	40% after RX deductible
Preferred	$35 Copay (30 Day Supply) $70 Copay (60 Day Supply) $105 Copay (90 Day Supply)	40% after RX deductible
Non-Preferred	$60 Copay (30 Day Supply) $120 Copay (60 Day Supply) $180 Copay (90 Day Supply)	40% after RX deductible
Specialty	30% after RX deductible	Not Covered
Mail Order Prescriptions		
Generic	$30 Copay (31-90 Day Supply)	40% after RX deductible
Preferred	$70 Copay (31-90 Day Supply)	40% after RX deductible
Non-Preferred	$120 Copay (31-90 Day Supply)	40% after RX deductible
Specialty	30% after RX deductible	Not Covered

Cost Per Pay Period (Bi-Weekly)	**Aetna MC POS (PPO) Plan**
Employee Only	$78.40
Employee + 1	$241.84
Employee + 2 or more	$402.21

FIND THE RIGHT AETNA DOCTOR OF FACILITY

You can locate a doctor or facility through Aetna's **Find a Doctor Online Directory.**

Aetna HMO AVN Plan

1. Log on to **www.aetna.com**
2. Choose **"Find a Doctor"**
3. Choose "**Plan from an employer"** under Guests
4. Under "Continue as a guest" – **Enter a 5-digit zip code, city, state or country to begin looking for a provider**
5. Select **"State Based Plan"**
6. Then select "**Aetna Value Network HMO"**
7. Click "**Medical Doctors & Specialists"**
8. Click "**All Primary Care Physicians"** and the provider listing will appear.
9. Your provider listing will include specific providers currently accepting your Aetna Health Plan. You must call and check with the provider before scheduling your appointment or receiving services to confirm if he/she is still participating in Aetna's network.

Aetna HMO FULL Plan

1. Log on to **www.aetna.com**
2. Choose **"Find a Doctor"**
3. Choose "**Plan from an employer"** under Guests
4. Under "Continue as a guest" – **Enter a 5-digit zip code, city, state or country to begin looking for a provider**
5. Select **"Aetna Standard Plans"**
6. Then select "**HMO"**
7. Click "**Medical Doctors & Specialists"**
8. Click "**All Primary Care Physicians"** and the provider listing will appear.
9. Your provider listing will include specific providers currently accepting your Aetna Health Plan. You must call and check with the provider before scheduling your appointment or receiving services to confirm if he/she is still participating in Aetna's network.

Aetna MC POS (PPO) Plan

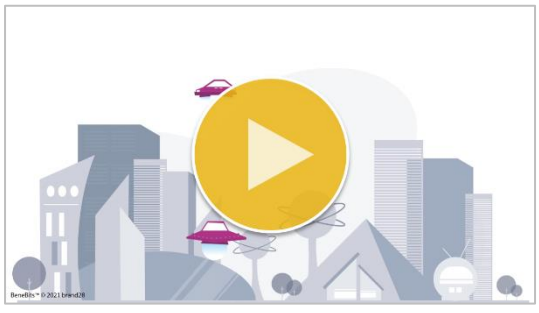
1. Log on to **www.aetna.com**
2. Choose **"Find a Doctor"**
3. Choose "**Plan from an employer"** under Guests
4. Under "Continue as a guest" – **Enter a 5-digit zip code, city, state or country to begin looking for a provider**
5. Select **"Aetna Open Access Plans"**
6. Then select "**Managed Choice POS (Open Access)"**
7. Click "**Medical Doctors & Specialists"**
8. Click "**All Primary Care Physicians"** and the provider listing will appear.
9. Your provider listing will include specific providers currently accepting your Aetna Health Plan. You must call and check with the provider before scheduling your appointment or receiving services to confirm if he/she is still participating in Aetna's network.

KNOW WHERE TO GO

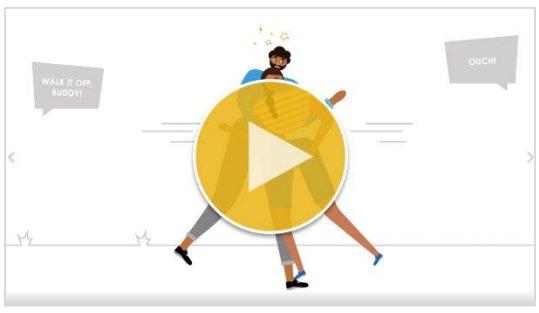
Where you get medical care can significantly influence the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

Type	Examples
Nurse line (24/7—$0) Quick answers from a trained nurse	• Identifying if immediate care is needed • Home treatment options and advice
Online visit (24/7—$) Many non-emergency health issues	• Cold, flu, allergies, headache, migraine • Skin conditions, rashes • Minor injuries • Mental health concerns
Office visit ($$) Routine medical care and management	• Preventive care • Illnesses, injuries • Managing existing conditions
Urgent care ($$$) Non-life-threatening conditions requiring prompt attention	• Stitches, sprains • Animal bites • High fever, respiratory infections
Emergency room (24/7—$$$$) Life-threatening conditions needing immediate care	• Suspected heart attack or stroke • Major bone breaks • Excessive bleeding • Severe pain • Difficulty breathing

Click to play videos



Virtual Healthcare



Urgent Care vs ER

PREVENTIVE CARE



An important part of self-care is getting preventive medical exams to check that you are staying healthy and to identify and treat issues before they become serious.

PREVENTION IS A HABIT

- Make healthy lifestyle choices —food, exercise, sleep, safety.
- Schedule an annual physical with your primary care doctor and follow your doctor's recommendations.
- Set health and wellness goals and work towards them daily.

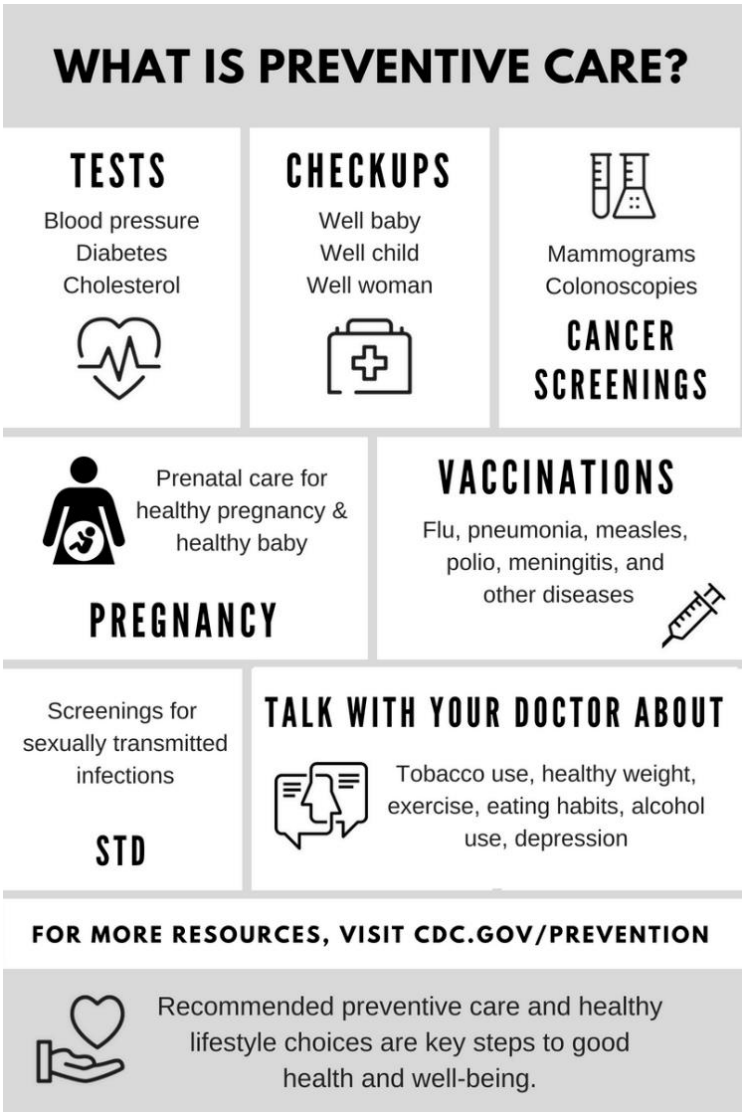
KNOW YOUR NUMBERS

Keep a record of your health screening dates and results so you can talk to your doctor about any changes.

- Date of last checkup
- Height and weight
- Blood pressure
- Cholesterol
- Immunizations and vaccines
- Other test results

WHAT PREVENTION CARE DO YOU NEED?

Visit healthfinder.gov and enter your age and sex in the app to get a list of recommended preventive screenings for your stage in life. Talk to your doctor about which are appropriate for you.



IS IT PREVENTIVE OR DIAGNOSTIC?

You benefit both financially and health-wise when you get annual medical checkups. Preventive care helps you avoid more serious and costly health problems down the road. Plus, it's free.

Did you know that, depending on the situation, the same test or service can be considered preventive (100% covered) or diagnostic (you share the cost)?

Preventive Care Services

- Help you stay healthy by checking for disease before you have symptoms or feel sick
- Can include flu shots and other vaccinations, physical exams, lab tests and prescriptions
- 100% covered when delivered by an in-network provider

Diagnostic Services

- Check for disease after you have symptoms or because of a known health issue
- Can also include physical exams, lab tests and prescriptions
- You pay your share of the cost

PREVENTIVE: At Don's annual checkup, his doctor orders a blood sugar test to screen for diabetes, even though Don does not have symptoms.

DIAGNOSTIC: Grace's doctor orders a blood sugar test because she complains of increased thirst, frequent urination, weight loss, and fatigue—all symptoms of diabetes.

PREVENTIVE: As part of her well woman exam, Vanessa receives a mammogram to make sure there have been no changes since last time.

DIAGNOSTIC: Darla visits her doctor because she found a lump. Her doctor schedules a mammogram and a biopsy to check for cancer.

PREVENTIVE: Aki's doctor orders lab work during his annual physical, including a cholesterol check.

DIAGNOSTIC: Hector was diagnosed with high cholesterol two years ago. He has blood tests twice a year to check his cholesterol levels and make sure his medication is the right dose.

If you are unsure why a test was ordered, ask your doctor. And don't forget to schedule your preventive care visits. Many people use a key date like their birthday or anniversary as a reminder to make their appointments each year.

PRESCRIPTIONS BREAKING YOUR BUDGET?

Click to play video

THE FORMULARY DRUG TIERS DETERMINE YOUR COST

$	Generic Drug
$$	Brand Name Drug
$$$	Specialty Drug

Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to be as effective as brand-name drug equivalents.

To find out if a drug is on your plan's formulary, visit the plan's website or call the customer service number on your ID card.

DENTAL

OUR PLAN(S)

- United Concordia DPPO Low Dental Plan
- United Concordia DPPO High Dental Plan

Click to play video

Why sign up for Dental coverage?

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance covers three types of treatments:

- **Preventive** care includes exams, cleanings and x-rays
- **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
- **Major** care goes further than basic and includes bridges, crowns and dentures
- **Orthodontia** treatment to properly align teeth within the mouth.

DENTAL PLANS

Did you know that regular dental checkups keep your smile bright and help keep your whole body healthy? Our dental coverage provides cleanings, exams, and x-rays. If there's a problem, your plan helps with the cost of dental work.

College Health Enterprises will continue to offer you **two dental plan options** available to you through United Concordia Dental. You may visit any dentist you choose, but you'll receive a higher level of benefits when you go to an in-network provider.

	United Concordia DPPO Low Dental Plan		**United Concordia DPPO High Dental Plan**	
Network	ELITE PLUS	OUT-OF-NETWORK	**ELITE PLUS**	OUT-OF-NETWORK
Annual Deductible	$50 per individual $150 per family Excludes Orthodontics		$50 per individual $150 per family Excludes Orthodontics	
Annual Plan Maximum	$1,500 Excludes Orthodontics		$3,000 Excludes Orthodontics	$2,000 Excludes Orthodontics
Preventive Care	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 100%	Plan pays 100%
Basic Services	Plan pays 60% after deductible	Plan pays 60% after deductible	Plan pays 90% after deductible	Plan pays 80% after deductible
Major Services	Plan pays 30% after deductible	Plan pays 30% after deductible	Plan pays 60% after deductible	Plan pays 50% after deductible
Orthodontia *(adults & children)*	Plan pays 50% up to the lifetime maximum of $2,000		Plan pays 50% up to the lifetime maximum of $2,000	

Cost Per Pay Period (Bi-Weekly)	**United Concordia DPPO Low Dental Plan**	**United Concordia DPPO High Dental Plan**
Employee Only	$0.00	$15.65
Employee + Spouse	$3.72	$35.94
Employee + Child(ren)	$4.97	$33.77
Family	$9.65	$59.21

It's easy to pull up your dental plan info on your smartphone or tablet—anytime, anywhere. Simply download the United Concordia Dental mobile app. It puts the details you need right in the palm of your hand.

Use the app to: See claims, deductible info and coverage details. Find in-network dentists near you. View your digital member ID card. Learn what to do in a dental emergency. Download our Chomper Chums® brushing app for kids.

VISION

OUR PLAN

- VSP Vision

Click to play video

Why sign up for Vision coverage?

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

You'll even find discounts on services like LASIK and PRK, rebates on contact lenses and other services. Visit the plan's website to check out these extra savings.

VSP VISION PLAN

College Health Enterprises s offers a comprehensive vision plan provided by VSP. The VSP Vision provider network includes thousands of professionally certified optometrists and ophthalmologists who offer comprehensive vision exams and ways to purchase glasses or contacts in office. You have the freedom to choose from both in and out-of-network vision providers.

College Health Enterprises will continue to pay for the **FULL** cost of Vision Benefits for their employees and family members.

VSP Vision		
	In-Network	**Out-of-Network**
Frequency		
Exams	12 Months	12 Months
Frames	24 Months	24 Months
Lenses	12 Months	12 Months
Contacts (Elective)	12 Months	12 Months
LightCare	24 Months	24 Months
Exam	$10 Copay	Up to $45
Frame Allowance	- $220 Featured Frame Brands - $200 Frame Allowance - 20% Savings on the Amount Over Your Allowance - $110 Costco Frame Allowance	Up to $70
Contact Lenses	Up to $60	Up to $105
Contacts Allowance	- $170 Allowance for Contacts; Copay does not apply	Up to $105
Lenses		
Single Vision	$15 Copay	Up to $30
Bifocal	$15 Copay	Up to $50
Trifocal	$15 Copay	Up to $65
LightCare	$200 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, in lieu of prescription glasses or contacts	$15
YOUR COVERAGE GOES FURTHER IN-NETWORK		
With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider.		

Cost Per Pay Period (Bi-Weekly)	VSP Vision
Employee Only	$0.00
Employee + 1	$0.00
Employee + 2 or more	$0.00

SunCare Plan

You know the sun can damage your skin, but did you know that it can damage your eyes too? Ultraviolet rays can be dangerous to your cornea and result in UV-related illnesses such as cataracts, cancer of the eyelids, pteryguim (tissue build-up on the whites of the eyes) and macular degeneration.

VSP® Vision care for life

Tips from the American Academy of Ophthalmology on protecting your eyes from the sun:

- Sun damage to eyes can occur anytime during the year, not just in the summertime, so be sure to wear UVA- and UVB-blocking sunglasses and broad-brimmed hats whenever you're outside.
- Don't be fooled by clouds—sun rays can pass through haze and thin clouds.
- Never look directly at the sun. Looking directly at the sun at any time, including during an eclipse, can lead to solar retinopathy, which is damage to the eye's retina from solar radiation.

Your SunCare Coverage with a VSP Doctor*	
Eye Exam	• A fully covered comprehensive eye exam[1]
Eyewear	• Use your frame allowance toward ready-to-wear, non-prescription sunglasses from a VSP doctor.

100%

UVA AND UVB PROTECTION

The best choice for your sunglasses.[2]

*Register and log on to **vsp.com** to review your benefit information. Based in applicable laws; benefits may vary by location.

Questions? **vsp.com** | **800.877.7195**.

1. Less any applicable copay **2.** EyeSmart.Org, Eye Health Information from the American Academy of Ophthalmology.

JOB#19459CM 12/14

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Click to play video

ARE YOU ELIGIBLE?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA.

Find out more

- Eligible Expenses – now include more over-the-counter items!
- Ineligible Expenses

HealthEquity®
WageWorks

Set aside healthcare dollars for the coming year

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year.

How the HealthEquity Flexible Spending Account (FSA) works

- You estimate what you and your family's out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, even eligible drugstore items.
- You can contribute up to **$3,200 (minimum $100)** the annual limit set by the IRS. Contributions are deducted from your pay pre-tax, meaning no federal or state tax is applied on that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.

Estimate carefully!

If you don't spend all the money in your account, you can roll over up to **$640** to use the following year. Any additional remaining balance will be forfeited.

Important considerations

- There's no "crossover" spending allowed between the healthcare and dependent care accounts.
- Elections cannot be changed during the plan year unless you have a qualified change in family status (and the election change must be consistent with the event).
- You can use your Health Equity FSA benefit account(s) to pay for the eligible expenses of a qualifying child or relative, as defined in Internal Revenue Code Section 152. Generally, a qualifying child or relative is:
  - Your spouse
  - Your dependent that you can claim on your tax return
  - Your adult child(ren) who will not attain age 26 by the end of the calendar year
- **Keep your receipts.** In most cases, you'll need to provide proof that your expenses were considered eligible for IRS purposes.
- If your employment at College Hospital ends and you have a remaining FSA balance, you have until the end of the year to use the funds for eligible expenses incurred through your termination date.

PAYING FOR DAYCARE? MAKE IT TAX-FREE!

Click to play video

EVERY OPPORTUNITY TO SAVE

The biggest deduction from your paycheck is likely federal income tax. Why not take a bite out of taxes while paying for necessary expenses with tax-free dollars?

Dependent Care FSA—up to $2,500 per year tax-free

A dependent care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by HealthEquity.

Here's how the Dependent Care FSA works

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only child care, but also before and after school care programs, preschool, and summer day camp for children younger than 13. The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care.

You can set aside up to $5,000 per household per year (if married and filing jointly) . You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

Estimate carefully! You can't change your FSA election amount mid-year unless you experience a qualifying event. Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year. Unspent funds will be forfeited.

Chick Here to see how much you can save!

EMPLOYEE ASSISTANCE PROGRAM

Help for you and your household members - There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through REACH can help you hand a wide variety of personal issue such as emotional health and substance use disorder; parenting and childcare needs financial coaching; legal consultation and eldercare resources.

Best of all, contacting the EAP is completely confidential, **free** and available to any member of your immediate household.

CONTACT REACH

PHONE: 1-800-273-5273
Crisis Line – 24/7 hours

Non-Emergency needs can call during regular business hours: 8 AM – 5 PM Monday through Friday

EMAIL: info@reachline.com

WEBSITE: www.reachline.com

ONLINE SERVICES

REACHline.com provides Self-Assessment Tools, Online Magazine, Links to Work/Life Skill Resources, and access to REACH Assistance!

1. Go to www.reachline.com
2. Click "**Members"** on top left tab
3. Enter Password: **reach**
4. Click on any areas desired

Service Points to Remember…

- REACH is confidential
- There is no charge to you
- Is it available for you and your immediate family members' problems that are too difficult
- Easy access to set up a counseling appointment
- Immediate phone access to a professional counselor, 24 hours, 7 days a week

WHY REACH ASSISTANCE? We all experience personal and work-related stressors at one time or another. Your employer cares that you get the right type of assistance for these problems. REACH has been contracted to confidentially give you immediate assistance and referral that will help you toward problem resolution.

WHAT REACH ASSISTANCE CAN ASSIST WITH?
REACH can assist you with all kinds of problems and work-related stressors. The most common are:

- *Relationships:* Family, Marital, Child
- *Addictions:* Substance Abuse, Internet, Sex, Gambling
- *Emotional:* Depression, Anxiety, Stress, Loss
- *Workplace:* Co-worker, supervisor
- *Legal:* Family, Personal Injury, Will, Criminal
- *Financial:* Debt, Credit, Budgeting, Retirement
- *ElderCare:* Caregiving, Retirement, Home Care
- *Parenting:* Single, Step, New

ARE SERVICES FREE? Yes. All services provided by REACH are prepaid by your employer for you and your dependents. However, continued treatment or if a referral is recommended by the REACH Staff, you will be responsible for any additional expenses. In many cases your health insurance will cover part of that cost, and the REACH staff will discuss the costs with you to ensure you get the help you need.

LIFE & DISABILITY

YOUR BENEFICIARY = WHO GETS PAID

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier— receives the benefit. **Make sure that you name at least one beneficiary for your life insurance benefit,** and change your beneficiary as needed if your situation changes.

Is your family protected?

Life, AD&D and disability insurance can fill a number of financial gaps due to a temporary or permanent reduction of income. Consider what your family would need to cover day-to-day living expenses and medical bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (rent or mortgage, children's education, student loans, consumer debt, etc.) after the death of a spouse or partner.

We provide Basic Life and AD&D insurance to help you recover from financial loss.

If you need additional coverage

We offer voluntary coverage that you can purchase for yourself, your spouse, and your children. See the Voluntary Benefits section for details.

LIFE AND AD&D INSURANCE

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you die in an accident. College Health Enterprises provides you with Basic Term Life and AD&D Coverage. This coverage is paid in full by **College Health Enterprises.** Coverage is provided by **MetLife**.

Annual Earnings	Basic Life and AD&D Coverage Amount
Less than $20,000	$7,000
$20,001 - $29,999	$12,000
$30,000 - $39,999	$20,000
More than $40,000	$50,000

Beneficiary Reminder: Make sure that you have included a beneficiary on your life insurance benefit. It's important to know that many states require that a spouse be named as the beneficiary unless they sign a waiver.

ADDITIONAL SERVICES: MetLife provides additional services listed out below to help you, your dependents and your beneficiaries to cope with loss.

- **Greif Counseling -** You, your dependents, and your beneficiaries have access to grief counseling1 sessions and funeral related concierge services to help cope with a loss — at no extra cost. Grief counseling services provide confidential and professional support during a difficult time to help address personal and funeral planning needs. You can access these services by calling 1-888-319-7819 or log on to www.metlifegc.lifeworks.com (Username: metlifeassist; Password: support).

- **Funeral Discounts and Planning Services -** As a MetLife group life policyholder, you and your family may have access to funeral discounts, planning and support to help honor a loved one's life — at no additional cost to you.

- **Life Settlement Account -** The Total Control Account® (TCA) settlement option provides your loved ones with a safe and convenient way to manage the proceeds of a life or accidental death and dismemberment claim payments of $5,000 or more, backed by the financial strength and claims paying ability of Metropolitan Life Insurance Company. Call 1-800-638-7283 for more information about options available to you.

VOLUNTARY BENEFITS

OUR VOLUNTARY PLANS

- Voluntary Supplemental Life Insurance
- MetLife Short-Term Disability
- Reliance Standard Long-Term Disability
- MetLife Accident
- MetLife Critical Illness
- MetLife Hospital Indemnity
- Legal Assistance and ID Theft Protection

You're unique—and so are your benefit needs

Voluntary benefits are optional coverages that help you customize your benefits package to your individual needs.

You pay the entire cost for these plans, but rates may be more affordable than individual coverage. And you get the added convenience of paying through payroll.

Voluntary benefits are just that: voluntary. You have the freedom and flexibility to choose the benefits that make sense for you and your family. Or, you don't have to sign up for voluntary benefits at all. The choice is yours.

VOLUNTARY SUPPLEMENTAL LIFE INSURANCE

Voluntary AD&D Insurance allows you to purchase additional accidental death and dismemberment insurance to protect your family's financial security in case you suffer from loss of a limb, speech, sight or hearing or if you die in an accident. **You pay the cost of coverage**. Coverage is provided by **MetLife**.

Employee Supplemental Term Life Insurance
Increments of $10,000 up to $200,000 (not to exceed 3X salary) **Guarantee Issue Amount:** $100,000

If you select a coverage amount above the guarantee issue amount, you will need to submit an Evidence of Insurability (EOI) form with additional information about your health for the insurance company to approve this higher amount of coverage.

ADDITIONAL SERVICES: MetLife provides additional services listed out below to help you, your dependents and your beneficiaries to cope with loss.

- **Estate Planning Services -** When you enroll for supplemental life coverage, you will automatically receive access to Estate Planning Services at no extra cost to you. Estate Planning Service offers unlimited access to complete wills and other important estate planning documents quickly and easily online with access to online notary services, or work one-on-one with a MetLife Legal Plans' attorney, in-person or on the phone, to prepare or update a will, living will, or power of attorney. Visit legalplans.com/estateplanning to get started.

VOLUNTARY SHORT-TERM DISABILITY

Short-Term Disability (STD) coverage, which provides benefits if you are unable to work for a limited period of time due to an illness or injury that is not work-related. STD covers of your base annual earnings up to a maximum per week for a maximum of weeks. Benefit begins on the of disability. Benefits from the STD plan will be reduced by any state-mandated benefits for which you are eligible. Coverage is provided by **MetLife.**

Monthly Benefit Amount	Plan pays 60% of monthly earnings in increments of $100 for employees working in states other than listed below. **Employees located in CA and RI:** Plan pays 25% of monthly earnings in increments of $100 **Employees located in NY, HI, NJ and PR:** Plan pays 40% of monthly earnings in increments of $100
Minimum Monthly Benefit	$300
Maximum Monthly Benefit	$3,000; and cannot exceed the salary of your monthly earnings
Benefits Begin After	Accident: 14 Days Sickness (including pregnancy): 14 Days
Maximum Duration of Benefit	12 Months

For STD Coverage – Benefits may be reduced by income from other income sources such as paid time off, and Social Security.

Additional Features: When you are ill or injured, MetLife believes you may need more than a supplement to your income. That's why we offer return to work services and incentives, including:

Nurse Consultant or Case Manager Services: Specialists who will contact you, your physician and your employer to coordinate an early return to work plan when appropriate.

Return to Work or Partial Disability Incentives: Allow you to receive Disability benefits or partial benefits while attempting to return to work.

Your Age:	Rate per $100 of monthly covered benefit:
Less than 50 years old	$4.94
Between the ages of 50-59	$5.87
60 and over	$8.27

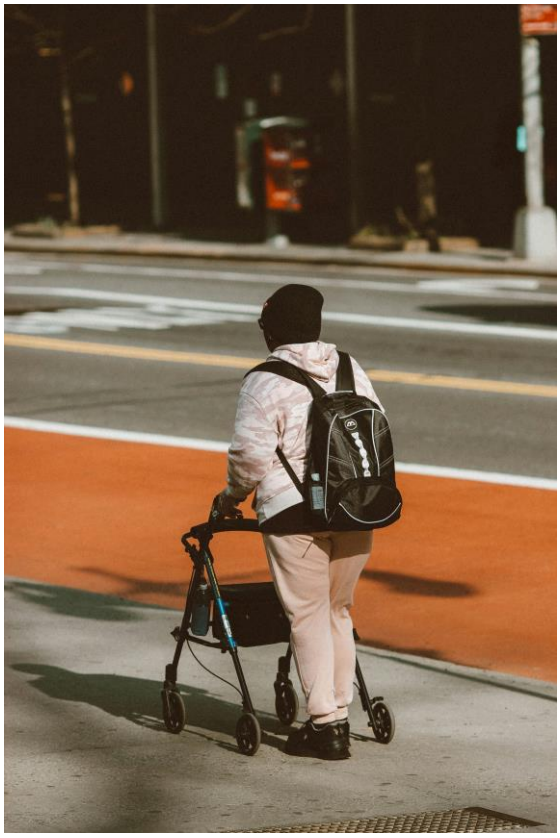
VOLUNTARY LONG-TERM DISABILITY

Long-Term Disability (LTD) insurance provides income protection by paying you a certain percentage of your income if you can't work because of a non-work-related injury or illness preventing you from performing any of your job functions over a long time. It's important to know that benefits are reduced by income from other benefits you might receive while disabled, like workers' compensation and Social Security. All benefits-eligible employees who earn an annual salary of at least $15,000 has access to purchase Voluntary Long-Term Disability insurance through **Reliance Standard**.

Monthly Benefit Amount	You may elect a monthly benefit in increments of $100, from a minimum of $100 up to a maximum benefit of $7,500 per month, not to exceed 60% of your covered earnings (rounded to the next lower increment).
Minimum Monthly Benefit	$100
Maximum Monthly Benefit	$7,500
Benefits Begin After	360 constitutive days of total disability
Maximum Duration of Benefit	Benefits will not extend beyond the longer of: Social Security Normal Retirement Age or Duration of Benefits below.

Age at Disablement	Duration of Benefits
61 or less	to age 65
62	3.5 years
63	3 years
64	2.5 years
65	2 years
66	1.75 years
67	1.5 years
68	1.25 years
69 or more	1 year

Coverage is 100% employee paid.



For LTD Coverage – Benefits may be reduced by income from other income sources such as paid time off, and Social Security.

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

VOLUNTARY ACCIDENT INSURANCE

Be better prepared when the unexpected happens. Accidents can happen at any time, and treatment can knock a household budget off course. We make accident insurance payments directly to you, not your healthcare provider, so you can use the money however you want. There are more than 150 covered events that pays benefits, in addition to any benefits that your medical plan may pay. Employees have the choice of a Low and High plan. Coverage is provided by **MetLife and** is **100% employee paid.**

Benefit Type	MetLife Accident - Low Plan Insurance Pays YOU	MetLife Accident - High Plan Insurance Pays YOU
Injuries		
Fractures[2]	$100 - $6000	$150 - $9000
Dislocations[2]	$100 - $6000	$150 - $9000
Second and Third Degree Burns	$100 - $10000	$150 - $15000
Skin Graft Benefit	50% of Burn Benefit	50% of Burn Benefit
Concussions	$400	$600
Coma	$10,000	$15,000
Ruptured Disk with Surgical Repair Benefit	$1,000	$1,500
Torn Cartilage in Knee Benefit	$750 or $150	$1000 or $200
Cuts/Lacerations	$50 - $400	$75 - $600
Torn/Ruptured/Severed Tendon/Ligament/Rotator Cuff Benefit	$150 - $1000	$200 - $1500
Broken Tooth Benefit	$50 - $200	$75 - $400
Eye Injuries	$300	$400
Medical Services & Treatment[1]		
Ambulance	$1000 or $300	$1500 or $400
Emergency Care	$50 - $200	$100 - $300
Non-Emergency Care	$50	$50
Medical Testing Benefit	$200	$300
Physician Follow-Up	$75	$100
Transportation Benefit	$400	$600
Therapy Services (including physical therapy)	$25	$35
Pain Management Benefit for Epidural Anesthesia	$100	$150
Prosthetic Device Benefit- varies by type and number of devices	$750 or $1500	$1000 or $2000
Medical Appliances	$100 - $1000	$200 - $1500
Modification Benefit	$1,000	$2,000
Blood/Plasma/Platelets Benefit	$400	$500
Inpatient Surgery	$200 - $2000	$300 - $3000
Outpatient Ambulatory Surgery Benefit	$300	$500

VOLUNTARY ACCIDENT INSURANCE (Cont.)

Benefit Type	MetLife Accident - Low Plan Insurance Pays YOU	MetLife Accident - High Plan Insurance Pays YOU
Hospital[3] Coverage (Accident)		
Admission	$1000 - $2000 per accident	$1500 - $3000 per accident
Confinement (non-ICU confinement paid for up to 31 days. ICU confinement paid for 31 days.)	$200 (non-ICU) - $400 (ICU) a day	$300 (non-ICU) - $600 (ICU) a day
Inpatient Rehab (paid per accident)	$200 a day, up to 15 days	$300 a day, up to 15 days
Accidental Death		
Employee receives 100% of amount shown, spouse receives 50% and children receive 20% of amount shown.	$50,000 $150,000 for common carrier[4]	$100,000 $300,000 for common carrier[4]
Other Benefits		
Lodging[5] - Pays for lodging for companion up to 31 nights per calendar year	$200 per night, up to 31 nights; up to $6200 in total lodging benefits available per calendar year	$300 per night, up to 31 nights; up to $9300 in total lodging benefits available per calendar year
Health Screening Benefit (Wellness)[6]- benefit provided if the covered insured takes one of the covered screening/prevention tests	$50 Payable 1x per calendar year	$50 Payable 1x per calendar year

MetLife offers group rates and payroll deduction, so you don't have to worry about writing a check or missing a payment! Your employee rates are outlined below:

MetLife Accident Insurance MONTHLY Rates		
Coverage Option	**MetLife Accident - Low Plan**	**MetLife Accident - High Plan**
Employee Only	$8.74	$12.69
Employee + Spouse	$16.60	$23.87
Employee + Child(ren)	$18.07	$25.79
Family	$22.24	$32.01

MetLife

VOLUNTARY CRITICAL ILLNESS INSURANCE

Critical illness insurance from can help fill a financial gap if you experience a serious illness such as cancer, heart attack or stroke. Upon diagnosis of a covered illness, a lump-sum, tax-free benefit is immediately paid to you. You choose a benefit amount that fits your paycheck and can cover yourself and your family members if needed. Coverage is provided by **MetLife and** is **100% employee paid.**

Voluntary Critical Illness	
Coverage Options	**Benefit Amount**
Employee	$10,000 or $20,000 or $30,000
Spouse / Domestic Partner	50% of the Employee's Initial Benefit
Dependent Child(ren)	50% of the Employee's Initial Benefit

Benefit Payment: Your plan pays a lump-sum Initial Benefit upon the first verified diagnosis of a Covered Condition. Your plan also pays a lump- sum Recurrence Benefit4 for a subsequent verified diagnosis of certain Covered Conditions as shown in the table below. A Recurrence Benefit is only available if an Initial Benefit has been paid for the same Covered Condition. There is a Benefit Suspension Period that applies to Recurrence Benefits. In addition, there is a Benefit Suspension Period that applies to Initial Benefits for different conditions.

Please refer to the table below for the percentage benefit payable for each Covered Condition:

Covered Conditions*	Initial Benefit	Recurrence Benefit
Benign Tumor Category		
Benign Brain Tumor	100% of Benefit Amount	100% of Initial Benefit Amount
Cancer Category		
Invasive Cancer	100% of Benefit Amount	100% of Initial Benefit Amount
Non-Invasive Cancer	25% of Benefit Amount	100% of Initial Benefit Amount
Skin Cancer	5% of Benefit Amount, but not less than $250	None
Cardiovascular Disease Category		
Coronary Artery Bypass Graft (CABG) - *where surgery involving either a median sternotomy or*	50% of Benefit Amount	100% of Initial Benefit Amount
Childhood Disease Category		
Cerebral Palsy	100% of Benefit Amount	None
Cleft Lip or Cleft Palate	100% of Benefit Amount	None
Cystic Fibrosis	100% of Benefit Amount	None
Diabetes (Type 1)	100% of Benefit Amount	None
Down Syndrome	100% of Benefit Amount	None
Sickle Cell Anemia	100% of Benefit Amount	None
Spina Bifida	100% of Benefit Amount	None
Functional Loss Category		
Coma	100% of Benefit Amount	100% of Initial Benefit
Loss of: Ability to Speak; Hearing; or	100% of Benefit Amount	None
Paralysis of 2 or More Limbs	100% of Benefit Amount	None

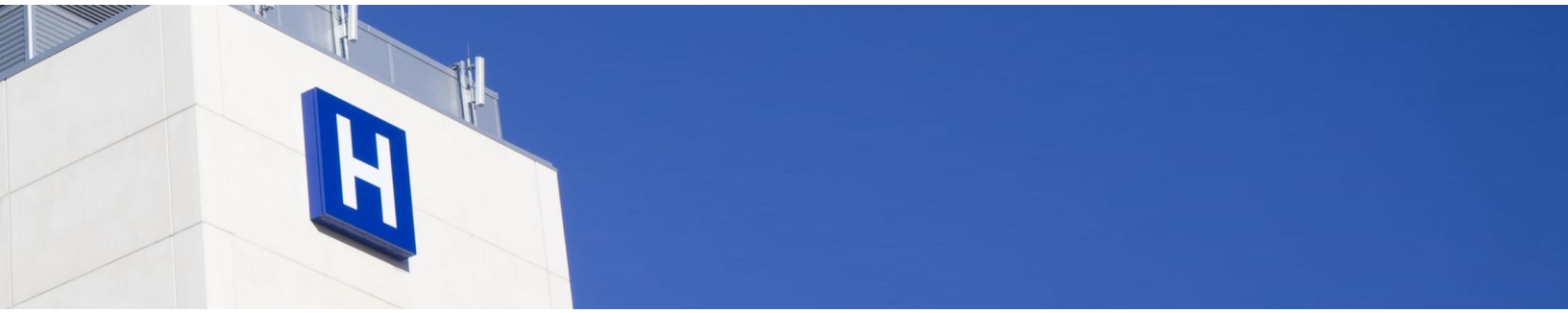
VOLUNTARY CRITICAL ILLNESS INSURANCE (Cont.)

Covered Conditions*	Initial Benefit	Recurrence Benefit
Heart Attack Category		
Heart Attack	100% of Benefit Amount	100% of Initial Benefit
Sudden Cardiac Arrest	100% of Benefit Amount	None
Infectious Disease Category		
Bacterial Cerebrospinal Meningitis	25% of Benefit Amount	None
COVID-19	25% of Benefit Amount	None
Diphtheria	25% of Benefit Amount	None
Encephalitis	25% of Benefit Amount	None
Legionnaire's Disease	25% of Benefit Amount	None
Malaria	25% of Benefit Amount	None
Necrotizing Fasciitis	25% of Benefit Amount	None
Osteomyelitis	25% of Benefit Amount	None
Rabies	25% of Benefit Amount	None
Tetanus	25% of Benefit Amount	None
Tuberculosis	25% of Benefit Amount	None
Kidney Failure Category		
Kidney Failure	100% of Benefit Amount	None
Major Organ Transplant Category		
Major Organ Transplant *For bone marrow, heart, lung,*	100% of Benefit Amount	None
Progressive Disease Category		
ALS	100% of Benefit Amount	None
Alzheimer's Disease	100% of Benefit Amount	None
Multiple Sclerosis	100% of Benefit Amount	None
Muscular Dystrophy	100% of Benefit Amount	None
Parkinson's Disease (Advanced)	100% of Benefit Amount	None
Systemic Lupus Erythematosus (SLE)	100% of Benefit Amount	None
Severe Burn Category		
Severe Burn	100% of Benefit Amount	100% of Initial Benefit
Stroke Category		
Stroke	100% of Benefit Amount	100% of Initial Benefit

Insurance Rates: MetLife offers group rates and payment of premium through payroll deduction, so you don't have to worry about writing a check or missing a payment! Your employee rates are per $1,000 of Coverage.

Rates can be provided to you through EOI.

VOLUNTARY HOSPITAL INDEMNITY INSURANCE



Hospital indemnity insurance can enhance your current medical coverage. The plan pays a lump sum, tax-free benefit when you or an enrolled dependent is admitted or confined to the hospital for covered accidents and illnesses. You can use the money you receive under the plan however you see fit, for paying medical bills, childcare, or for regular living expenses like groceries—you decide. Coverage is provided by **MetLife and** is **100% employee paid.**

With MetLife, you'll have a choice of two comprehensive plans (called the "Low Plan" and the "High Plan") which provide lump sum cash payments in addition to any other payments you may receive from your medical plan. Here are just some of the covered benefits/services, when an accident or illness puts you in the hospital.

			Low Plan	High Plan
Admission Benefit	1 time(s) per calendar year	Admission	$500	$1,000
		ICU Supplemental Admission (Benefit paid concurrently with the Admission benefit when a Covered Person is admitted to ICU)	$500	$1,000
Confinement Benefit	15 days per calendar year	Confinement[1]	$100	$200
	ICU Supplemental Confinement will pay an additional benefit for 15 of those days	ICU Supplemental Confinement (Benefit paid concurrently with the Confinement benefit when a Covered Person is admitted to ICU)	$100	$200
Newborn Confinement Benefit	2 day(s) per confinement	Newborn Confinement[2]	$25	$50

Insurance Rates: MetLife offers group rates and payroll deductions, so you don't have to worry about writing a check or missing a payment!

MetLife

Monthly Cost to You	Low Plan	High Plan
Employee	$12.69	$23.18
Employee + Spouse	$27.07	$49.43
Employee + Child(ren)	$20.04	$36.60
Employee + Family	$34.42	$62.85

VOLUNTARY LEGAL SUPPORT AND ID THEFT PROTECTION

Do you need your Will prepared or updated?
Have you received a moving traffic violation?
LegalShield can help!

LegalShield℠

The LegalShield Membership Includes:

- **Dedicated Law Firm** – Direct access, no call center
- **Legal Advice/Consultation** on unlimited personal issues
- **Letters/Calls** made on your behalf
- **Contacts/Documents Reviewed** up to 15 pages each
- **Residential Loan Document Assistance** for the purchase of your primary residence
- **Will Preparation** – Living Will, Health Care Power of Attorney, Financial Power of Attorney
- **Speeding Ticket Assistance –** Upload your speeding ticket form the mobile app directly to law firm
- **IRS Audit Assistance** (begins with the tax return due April 15th of the year you enroll)
- **Trail Defense** (if named defendant/respondent in a covered civil action suit)
- **Uncontested Divorce, Separation, Adoption and/or Name Change Representation** (available 90 days after enrollment)
- **25% Preferred Member Discount** on Bankruptcy, Criminal Charges, DUI, Personal Injury, etc.
- **24/7 Emergency Access** for covered situations

Plan	Family-Price (Bi-Weekly)	Individual Price (Bi-Weekly)
LegalSheild	$7.36	$7.36
IDSheild	$7.36	$7.36
Combined	$13.34	$11.26

Worried about being a victim of identity theft?
Been concerned about your child's identity?
Lost your wallet? - **IDlShield** can help!

IDShield™

The IDShield Membership Includes:

- **1Byreau Credit Monitoring** from TransUnion with activity alerts
- **HighRisk Application and Transaction Monitoring** detects fraud up to 90 days earlier than traditional credit monitoring services. We carefully watch you accounts, reorders, loans and more. If a new account is opened, you will receiver an alert.
- **Social Media Monitoring** for privacy and reputational risks
- **Credit Inquiry Alerts** when your Personally Identifiable Information (PII) is used to apply for bank/credit cards, utilities or rentals, and many other types of loans
- **Consultation** on any cyber security question
- **$1 Million Protection Policy** coverage for lost wages, legal defense fees, stolen funds and more
- **Unlimited Service Guarantee** ensures than we won't give up until your identity is restored!
- **Identity Restoration** performed by Licensed Private Investigators to restore your identity to is pre-theft status.
- **24/7 Emergency Access** in the event of an identity theft emergency

For more information, contact you Independent Associate:

Christa Aufdemberg
714-904-6501
Christaca@legalshieldassociate.com

Put your law firm and identity theft protection in the palm of your hand with LegalShield & IDSheield Plus mobile apps

FINANCIAL WELLNESS

PLANS TO HELP YOU SAVE

- 401(k) Retirement Savings Plan

Is it time for a “financial wellness” checkup?

Are you worried about money—making your paycheck last? Paying down debt? Making a big purchase like a car or home? What about retirement?

Ignoring your financial health can take a toll on your quality of life today and in the future. And worrying about money can make you stressed, even to the point of physical illness.

We offer a retirement savings plan to help you make the most of your money.

Save for the future you envision

A quick guide to enrolling into your retirement savings plan

College Health Enterprises
401(k) Savings Plan

PLAN | INVEST | PROTECT

VOYA FINANCIAL

The choices you make about your contributions and investments are up to you. And you can easily make changes anytime online, on the phone, or with the Voya Retire mobile app. Remember, you are always in control.

Reasons to save today

1

Save automatically

Your contributions are automatically deducted from your paycheck, so it's simple to set a little aside each pay period.

2

Help lower your taxable income

Every dollar you contribute before taxes reduces your taxable income, which means you may pay less in income taxes today.

3

Invest your way

Would you prefer to make investment elections yourself or would you appreciate having some guidance? How much investment risk are you willing to tolerate? No matter what you decide, we offer investment solutions designed to fit your style.

4

Remember, your money is all yours

What you contribute and any related earnings are yours to take with you, even if you change jobs.

5

Put time on your side

Investing over a longer period of time in a tax-favored account allows you to take advantage of compounding, meaning any earnings on contributions go back into your account without being taxed and can generate its own earnings.

6

Employer Contributions

Take advantage and maximize your savings. Your company matches a portion of the contributions you make to the plan. For more details, please review Employer Contributions under Get to know your plan.

Remember, it's your retirement. Be generous.

GET TO KNOW YOUR PLAN

College Health Enterprises

401(k) Savings Plan

Introduction

This section describes highlights of your employer's retirement plan. It represents a general overview of the information printed in your employer's Summary Plan Description (SPD). Your retirement program is more fully described in the formal provisions of your employer's plan document. If there is a conflict between these plan highlights and your SPD, the language provided in the plan document will govern.

Eligibility Requirements

You are eligible to participate in the plan when you are 21 years of age.

Enrollment Dates

Once you have met the eligibility requirements, you can join the plan quarterly.

Employee Contributions

You may contribute O - 100% of your annual pay, not to exceed $23,000 annually. Annual limitations are set by the IRS and are subject to change. The tax laws may also let you contribute an additional amount over the regular annual limit if you are at least 50 years old. Check with your benefits manager to see if you can take advantage of the increased opportunity to 'catch up' and contribute even more to your employer's plan. If your adjusted gross income does not exceed certain limits, you may be eligible for a tax credit.

Roth Contributions

Your plan permits Roth after-tax employee contributions. You may contribute a minimum of 1% and your total employee contributions (Roth after-tax and Traditional pre tax deferrals combined) may not exceed $23,000 annually ($30,500 if you are at least age 50 and your plan has a catch-up feature). Annual limitations are set by the IRS and are subject to change.

Employer Contributions

Profit Shoring

Your employer has established a Profit Sharing plan. A Profit Sharing plan is a tax-qualified retirement plan in which your employer makes contributions on your behalf. The amount of the contribution is determined by an allocation formula that is generally based on participant earnings, while annual contributions are generally based on the company's profits. Contributions may be modified during times of business hardship.

Employer Match

Your employer may match a portion of the contributions you make to the plan.

Vesting

You will always be 100% vested in the portion of your account attributable to your Employee contributions. You are also 100% vested upon your death, normal retirement, or disability. Your employer contributions are subject to the following vesting schedule:

Employer Match Contributions

1 year of service 0% 2 years of service 20% 3 years of service 40% 4 years of service 60% 5 years of service 80% 6 years of service 100%

Profit Shoring Contributions

1 year of service 0% 2 years of service 20% 3 years of service 40% 4 years of service 60% 5 years of service 80% 6 years of service 100%

Rollovers

Money from other qualified plans is accepted. Rollover contributions are allowed prior to meeting the eligibility requirements of the plan.

Contribution Change Frequency

You may stop contributions at any time. Once you have stopped, you may resume contributions each pay period. You may also increase or decrease contributions each pay period.

Investment Transfers

Using Voya's automated telephone or Internet service, you have the ability to review your accounts and transfer funds from one investment option to another, 24-hours a day.

Hardship Withdrawals

Hardship withdrawal may be taken in case of extreme hardship as defined by the IRS when no other sources are available.

In-Service Withdrawals

In-service withdrawals are permitted by your plan.If your Plan allows for distributions prior to age 59 1/2, these distributions will be subject to an early distribution penalty of 10% additional tax unless certain exceptions apply. This tax applies to the amount received that you must include in income. Generally, there are restrictions on what dollars are available for in-service distribution. See your Summary Plan Description for more detail.

Distribution & Withdrawals

Funds are available at retirement, death, disability, or termination of service.

Loan Provision

You may take a loan from vested amounts in your account. The amount the Plan may loan to you is limited by rules under the Internal Revenue Code. Any new loans, when added to the outstanding balance of all other loans from the Plan, will be limited to the lesser of: a) $50,000 reduced by the excess, if any, of your highest outstanding balance of loans from the Plan during the one-year period ending on the day before the date of the new loan over your current outstanding balance of loans as of the date of the new loan; orb) 1/2 of your vested interest in the Plan. The amount the Plan may loan to you can also be limited by Plan rules such as which Employee and Employer Contributions are available for loan use, the number of loans that can be outstanding at any one time or how often you may request a loan. For specific details please refer to your Summary Plan Description (SPD). When thinking about taking a loan from your plan, keep in mind that when money is withdrawn from a retirement savings account, it reduces the power of tax-deferred compounding.

Participant Account Statements

Your investment statements are provided quarterly.

Now that you've envisioned your future retirement take the necessary steps today.

Enroll now:

Click:
myretirementbenefit.voya.com/1d6u

Plan Number: 81N882

Plan verification number: 81N88299

Scan:

Already enrolled? Great.

Access your account anytime, anywhere 24/7

Your plan website and the Voya Retire mobile app,allow you to securely manage your retirement savings anytime, anywhere. You can learn more, make any changes or just check on your progress toward your goals. If you need additional help, Voya customer service associates are available weekdays from 8 a.m. to 9 p.m., ET, excluding stock market holidays.

800-584-6001

VoyaRetirementPlans.com

Search **Voya Retire** in your favorite app store

You'll also have access to plan highlights and disclosures please visit myretirementbenefit.voya.com/1d6u.

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Voya.com

VOYA FINANCIAL

PLAN CONTACTS

Plan Type	Carrier	Policy #:	Phone Number	Website
Medical	Aetna PPO	174949	877-204-9186	www.aetna.com
Medical	Aetna HMO	174949	800-445-5299	www.aetna.com
Medical (Teladoc)	Aetna Teladoc	174949	855-835-2362	www.Teladoc.com/aetna
Medical	Kaiser	229189	800-464-4000	www.kp.org
The Difference Card	The Difference Card	N/A	888-343-2110	www.differencecard.com
Dental	United Concordia	923785	800-332-0366	www.unitedconcordia.com
Vision	VSP	12151324	800-877-7195	www.vsp.com
Flexible Spending Account	Health Equity	N/A	877-924-3967	www.healthequity.com
Dependent Care FSA	Health Equity	N/A	877-924-3967	www.healthequity.com
Employee Assistance Program	REACH	N/A	800-273-5273	www.reachline.com
Life Insurance	MetLife	1233224	1-800-GET-MET8	www.mybenefits.metlife.com
Grief Counseling	MetLife	0233224	888-319-7819	www.metlifegc.lifeworks.com
Voluntary Life Insurance	MetLife	0233224	1-800-GET-MET8	www.mybenefits.metlife.com
Voluntary Short-Term Disability	MetLife	0233224	1-800-GET-MET8	www.mybenefits.metlife.com
Voluntary Long-Term Disability	Reliance Standard	VPL302444	800-351-7500	https://www.reliancematrix.com/
Voluntary Accident Insurance	MetLife	0233224	1-800-GET-MET8	www.mybenefits.metlife.com
Voluntary Critical Illness	MetLife	0233224	1-800-GET-MET8	www.mybenefits.metlife.com
Voluntary Hospital Indemnity	MetLife	0233224	1-800-GET-MET8	www.mybenefits.metlife.com

GLOSSARY

-A-

AD&D Insurance
An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount
The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)
A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit
A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service.
After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference.

Beneficiary
The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA
A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Co-insurance
Your share of the cost of a healthcare visit or service. co-insurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your co-insurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Co-payment
A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the co-payment (sometimes called a co-pay) at the time you receive care. In most cases, co-pays do not count toward the deductible.

-D-

Deductible
The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

Dental Basic Services
Services such as fillings, routine extractions and some oral surgery procedures.

Dental Diagnostic & Preventive Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments.
Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)
An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for child(ren) under age 13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service
A service that your health plan doesn't pay for or cover.

-F-

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug
A drug that has the same active ingredients as a brand name drug, but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA) An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA)
A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance co-payments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

High Deductible Health Plan (HDHP) A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) may make you eligible for ahealth savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

-I-

In-Network
In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Out-of-network services will cost more, or may not be covered. Check your plan's website to find doctors, hospitals, labs, and pharmacies that belong to the network.

GLOSSARY

-L-

Life Insurance
An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance
Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order
A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment
The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network
Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of- network services at all.

Out-of-Pocket Cost
A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum
Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Outpatient Care
Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy
A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services
Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)
The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP, and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine / Teledoc
A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations
Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit
An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

2024

Annual Notices

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ACA Section 1557 Nondiscrimination Notice

Discrimination is Against the Law

The Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Company:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact the Plan Administrator.

[THE FOLLOWING APPLIES ONLY TO EMPLOYERS WITH 15 OR MORE EMPLOYEES]

If you believe that The Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Plan Administrator in person or by mail, fax, or email.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human
Services 200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Genetic Information Nondiscrimination Act Of 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Medicare Part D Notice

Important Notice from College Health Enterprises About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with [Insert Name of Entity] and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. College Health Enterprises has determined that the prescription drug coverage offered by the Aetna HMO Value Plan, Aetna HMO Full Plan, Aetna MC POS Plan and Kaiser HMO with The Difference Card Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your College Health Enterprises coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan. **Important Note for Retiree Plans:** Certain retiree plans will terminate RX coverage when an individual enrolls in Medicare Part D and individuals might not be able to re-enroll in that coverage. If completing this Notice for a retiree plan, review the plan provisions before completing this form and modify this section as needed.

Since the existing prescription drug coverage under College Health Enterprises is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your College Health Enterprises prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with College Health Enterprises and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information or call College Health Enterprises Human Resources. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through College Health Enterprises changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at socialsecurity.gov, or call them at 800-772-1213 (TTY 800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	March 2024
Name of Entity/Sender:	College Health Enterprises
Contact-Position/Office:	Alex Krieger, Chief People Officer
Address:	301 Victoria Street, Costa Mesa, CA 92627
Phone Number:	949-574-3385

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in Employer's health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in Employer's health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in Employer's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Availability of Privacy Practices Notice

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan

We maintain the HIPAA Notice of Privacy Practices for College Health Enterprises describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting plan administrator.

Notice of Choice of Providers

The Aetna HMO Value, HMO Full and Kaiser HMO Plans generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Aetna or Kaiser designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Aetna HMO Value, HMO Full and Kaiser HMO Plans or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the plan administrator.

Michelle's Law

The Aetna HMO Value, HMO Full and Kaiser HMO Plans may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school—or change in school enrollment status (for example, switching from full-time to part-time status)—starts while the child has a serious illness or injury, is medically necessary and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, as soon as the need for the leave is recognized. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility—

ALABAMA – Medicaid
Website: http://myalhipp.com/ | Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/ | Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 | Fax: 916-440-5676 | Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html

Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra | Phone: 678-564-1162, press 2

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ | Phone: 1-877-438-4479
All other Medicaid Website: https://www.in.gov/medicaid/ | Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: https://dhs.iowa.gov/ime/members | Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki | Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884 | HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx | Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003 | TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800-977-6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218 | Toll-free number for the HIPP program: 1-800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html | Phone: 1-800-701-0710

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: https://www.hhs.nd.gov/healthcare | Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742

OREGON – Medicaid

Website: http://healthcare.oregon.gov/Pages/index.aspx | Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) | CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov | Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: http://dss.sd.gov | Phone: 1-888-828-0059

TEXAS – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: https://medicaid.utah.gov/ | CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select or
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/

Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 8.39% in 2024 of your modified adjusted household income.

The 'No Surprises' Rules

The "No Surprises" rules protect you from surprise medical bills in situations where you can't easily choose a provider who's in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you're no longer in need of emergency care. These are called "post-stabilization services." You shouldn't get this notice and consent form if you're getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren't required to sign the form and shouldn't sign the form if you didn't have a choice of health care provider or facility before scheduling care. If you don't sign, you may have to reschedule your care with a provider or facility in your health plan's network.

View a sample notice and consent form (PDF).

This applies to you if you're a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

NOTES:

NOTES:

College Hospitals
Costa Mesa